Family Environment and Pediatric Overweight: What Is a Parent to Do?

LORRENE D. RITCHIE, PhD, RD; GREG WELK, PhD; DENNIS STYNE, MD; DANA E. GERSTEIN, MPH, RD; PATRICIA B. CRAWFORD, DrPH, RD

ABSTRACT
Although the causes of pediatric overweight are many and the levels of intervention required to prevent overweight in children extend from the child's immediate environment to the larger societal level, one critical intervention target is the parent. Scientific evidence points to specific dietary and physical activity/inactivity behaviors that families can adopt to encourage healthful weight status. Dietary recommendations include providing children with ample access to nutrient-dense foods and beverages and high-fiber foods, both at meals and snack times, reducing children's access to high-calorie, nutrient-poor beverages and foods both when eating at home and at restaurants, avoiding excessive food restriction or use of food as a reward, and encouraging children to eat breakfast on a daily basis. Physical activity recommendations include providing opportunities and encouragement for children to be physically active while reducing children's television and video game time. Parental modeling of healthful eating and physical activity practices is recommended to reinforce these patterns in youth. Dietetics professionals, physicians, and other health care professionals can assist parents in their efforts to prevent pediatric overweight by providing information and supporting these key behaviors, while working to create environments that support healthful lifestyle changes.


Pediatric overweight results from an interaction between environmental and genetic factors. However, steeply increasing rates of obesity among diverse youth from early childhood through adolescence, in a period spanning only 20 years, point to the predominant role played by a changing environment exerting effects on a stable genetic susceptibility.

A child's environment is complex, including family, peers, school, community, and the society at large as filtered through media, advertising, and prevailing social norms. The role of parenting is particularly critical for young children because parents directly determine the child's physical and social environment and indirectly influence behaviors, habits, and attitudes through socialization processes and modeling. To the extent that overweight is a function of environment, parents of young children may play a significant role in the prevention of childhood overweight.

What, then, should parents do? A significant body of literature focuses on child nutrition and feeding practices and children's physical activity (and sedentary behavior or physical inactivity), factors generally acknowledged to have an important impact on weight in children. The literature points to specific dietary and physical activity behaviors that may encourage healthful weight status.

This review briefly surveys the literature on modifiable influences on childhood weight gain that are subject to parental impact, identifies key references, and suggests specific ways in which parents influence children's risk for overweight/obesity. Seven guidelines are provided for creating a less "obesigenic" family environment. These guidelines can help dietetics professionals, physicians, or other clinicians counsel parents about establishing appropriate diet and physical activity practices for their children.

FOCUS OF CURRENT RESEARCH
Inherent problems of research design have sometimes made it difficult to determine the modifiable risk factors that predispose youth to overweight. Cross-sectional studies are limited by their inability to determine causal direction. For example, because excess body fat presents physical, social, and behavioral barriers that may limit participation in physical activities, children may become inactive as a result of their weight. Similarly, children...
who are overweight may make dietary adjustments, such as skipping breakfast, in response to overweight. The present review therefore emphasizes results of key longitudinal studies. However, large nationally representative studies, although cross-sectional, are also included if available. Both positive protective influences and negative risk factors will be discussed.

**Protective Influence of High Nutritive Value Foods**

Certain nutrient-dense foods, such as fruits, vegetables, and dairy products, which have high nutritive value relative to their energy content, have been demonstrated to be protective against childhood overweight (1-6). In the case of fruit and vegetable consumption, no longitudinal studies have yet been conducted, but one nationally representative cross-sectional study in the United States demonstrated an inverse association between pediatric overweight and fruit consumption for children between the ages of 5 and 18 years. In the same study, an inverse association was observed between overweight and vegetable intake among boys, but not among girls (4). Interventional data are needed to confirm results, but preliminary data suggest protective effects from fruit and vegetable consumption. Controlled studies that distinguish the potential influence of different types of fruits and vegetables (eg, sorting potatoes into fried and nonfried varieties) will clarify these effects.

A high intake of dietary fiber, found in most plant-based foods, such as whole grains, legumes, nuts, fruits, and vegetables, also may be protective against adiposity. Evidence from observational studies among adults is fairly consistent (10,11), although the evidence from studies in children is less compelling (12-15). In a recent review, Pereira and Ludwig concluded that fiber-rich diets should be promoted for the prevention of overweight in children (16). The World Health Organization also endorsed high-fiber foods as key elements of a diet for weight management (17).

High calcium and/or dairy intake may also provide protection against obesity (7). A 3-year prospective, longitudinal study of preschool girls found that as calcium intake increased, body fat decreased (1,6). Depending on the other variables included in the model, longitudinal dietary calcium intake explained 4.5% to 9.0% of the variability in body fat among the children at 8 years of age. This finding was corroborated in 6- to 19-year-old girls using nationally representative cross-sectional data in which body mass index (BMI) was inversely associated with milk intake (5). Other cross-sectional or case-control studies have confirmed these associations (2,3).

Breastfeeding has also been examined in relation to adiposity. In a recent meta-analysis of nine studies including a total of almost 70,000 participants, a significant inverse association was found between having been breastfed and subsequent childhood overweight. In addition, a dose-response relationship between the duration of breastfeeding and the prevalence of overweight was observed (8). This protective effect may be due to not only the nutrient composition of breast milk, but also to the presence of bioactive substances that may favorably impact metabolism, and to the process of breast-feeding itself, which may facilitate infant self-regulation of energy intake (9).

**Risks Presented by Low–Nutritive-Value Foods**

Excessive consumption of low–nutritive-value foods and beverages that contain high amounts of energy but few nutrients or fiber increases the risks of overweight/obesity. The evidence is stronger for some food types than for others, but this may be due in part to methodological issues.

To the extent that overweight is a function of environment, parents of young children may play a significant role in the prevention of childhood overweight.

Sweetened beverage consumption has been steadily increasing among children (18), and extensive evidence from a comprehensive review of the literature suggests that sugar in liquid is more “obesigenic” than other forms of sugar (19). Additionally, children’s soft drink consumption has been shown to be positively associated with their daily energy intake (20), while providing little nutritive value. A study of children ages 11 to 12 years observed for 2 years demonstrated a significant association between increased servings of sweetened beverages and subsequent increases in BMI and skinfold values (21). Children who consumed two servings of sweetened beverages per day, as compared with those who did not, tripled their likelihood of being overweight. Another 2-year longitudinal study of slightly older children, 9 to 14 years of age at baseline, found similar results (22). Further, in a large, nationally representative study of children 2 to 19 years of age, overweight was related to percent of energy obtained from soft drinks (23). Although findings from other cross-sectional studies were inconsistent, these studies were in general smaller and/or of weaker design. A recent school-based education intervention that specifically targeted reductions in soda consumption corroborated the positive association between sweetened beverage intake and adiposity (24). In this randomized, controlled, 1-year trial involving children 7 to 11 years of age, intake of carbonated drinks decreased by a mean of 50 mL/day in the intervention group, whereas children in the control group increased their intake by approximately 20 mL/day, a difference that was significant. Correspondingly, the percentage of overweight children decreased by 0.2% in the intervention group and increased by 7.5% in the control group.

Frequent consumption of food away from home has also been linked with adiposity. In the first longitudinal study on this topic, children who ate at fast-food establishments two or more times per week were more likely to increase their relative BMI than those who patronized fast-food establishments once per week or less (25). In a recent case-control study, overweight adolescents consumed more energy (relative to estimated requirements) than their leaner counterparts when provided the same fast-food meal. On days when fast food was consumed, the overweight adolescents also consumed more energy than their leaner counterparts did (26). In addition to higher energy intake,
eating away from home has been associated with consuming less quality food (ie, more fat, added sugars, and sugar-sweetened beverages, and less milk, fiber, fruits, and nonstarchy vegetables) (27-29). In addition to the nutrient composition of the foods offered, larger portion sizes, and high levels of palatability, choice and variety may contribute to the larger amount of energy consumed at meals eaten at fast-food restaurants compared with those eaten in the home (30-32).

Data on the number of snack occasions and adiposity are mixed (33,34), in part for methodological reasons (ie, there is little consensus about the definition of a snack), and in part because snack occasions vary by size and by their component foods. Snacks do tend to be higher in energy density and proportion of energy from fat than meals (35), and high snack consumption has been associated with high intakes of fat, sugar, and energy (36,37). Snacking has frequently been shown to be a risk factor for obesity among adults (38), and there is sufficient basis for minimizing excess consumption of snack-type foods. Providing parents with clear information about appropriate foods to serve their children between meals is likely to be a successful tactic to lay the foundation for healthful eating habits, which may ultimately help prevent overweight and other health problems during and after childhood (39).

Numerous studies in both adults and children have shown that overweight individuals are more likely to skip breakfast than their leaner counterparts.

One pattern that may be particularly important to reinforce is breakfast consumption. Numerous studies in both adults and children have shown that overweight individuals are more likely to skip breakfast than their leaner counterparts. One large nationally representative study examined data from 24,363 children measured in the Nationwide Food Consumption Survey and the Continuing Survey of Food Intakes by Individuals, spanning the years 1965 to 1991, and found a positive relationship between breakfast skipping and self-reported BMI in adolescents, but not in children (40). A recent analysis of data collected longitudinally from children 9 to 17 years old found that breakfast skipping was associated with a 1-year relative decrease in BMI among overweight youth, while there was a trend among non-overweight youth toward the opposite, breakfast skipping being related to an increase in BMI (41).

It should be noted that these analyses were based on self-reported heights and weights, which may have introduced a bias. Without longitudinal data using measured BMI and studies that control for other health-related factors, particularly dieting behaviors, it remains unclear whether skipping the morning meal is a result of an effort to lose weight or a contributing factor to excessive weight gain. However, in adults, breakfast skipping and BMI have been positively associated even after analyses were controlled for dieting behaviors (42,43). Further, breakfast skipping has been associated with other risks, such as poor nutrient intakes and lower cognitive function (44).

Protective Influence of Regular Physical Activity

Although population-wide decreases in physical activity have often been cited as contributing to the increasing prevalence of obesity, there is little evidence to support this contention. The available data do not reveal a secular trend for decreasing levels of activity in youth (45), but methodological challenges associated with measuring physical activity may cloud this type of research. Secular trends for decreasing involvement in physical education at school are evident in the Youth Risk Behavior Survey (46). Decreases in the percentage of youth walking to school have also been noted. Decreases in lifestyle activity and free play may not be captured in existing surveillance instruments, but they may collectively contribute to a reduction in total energy expenditure from physical activity in children today.

Several large nationally representative longitudinal studies have reported significant protective associations between physical activity and BMI, and these results were consistent for both boys and girls and among different ethnic groups (47,48). Cross-sectional results from nationally representative studies have yielded more equivocal findings. Two analyses from the Youth Risk Behavior Survey reported significant inverse associations between physical activity and BMI (49,50). Results from two analyses of the National Health and Nutrition Examination Survey (NHANES) (51,52), however, reported nonsignificant associations. The nature of the physical activity question in the NHANES dataset may explain the lack of association in these studies. The strength of the longitudinal studies and the generally significant associations from other cross-sectional studies (53,54) support physical activity as protective against overweight in youth.

Risks from Inactivity and Sedentary Behaviors

Among children, physical inactivity is typically quantified as time spent watching television and/or playing video games because these are common inactive pursuits. Large periods of inactivity may not only reduce the likelihood of physical activity, but the physical and behavioral manifestations of these sedentary pursuits also seem to directly influence obesity risk.

Early research examining relationships between inactivity and risk for overweight were somewhat equivocal, but recent studies have more consistently reported significant associations between these variables. Nationally representative data from the AddHealth project indicated that the odds of becoming overweight were 40% to 50% higher for youth reporting high amounts of television viewing (48). Another large longitudinal study found a direct association between television viewing and annual increases in BMI among children (13). Cross-sectional results from the large nationally representative datasets have revealed significant associations between television and obesity, but the results have been more consistent in girls than in boys (49,51,52,55).

An issue with television research is that it is possible
for children to watch large amounts of television in a day and still be physically active. The more important risk profile seems to be the combination of high amounts of television viewing and low activity. Results from several longitudinal studies have confirmed that inactivity and low levels of physical activity have an additive effect on increasing risks for obesity in youth (13,48). Intervention research aimed at reducing inactivity has generally been more successful than interventions designed to promote activity. In one randomized, controlled, school-based trial, children who received 6 months of classroom lessons to reduce television, videotape, and video game use experienced significantly smaller gains in BMI and other measures of adiposity relative to children in the control group (56).

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Most studies have specifically evaluated television viewing, but others have examined the independent effect of video games. The results from two longitudinal studies support associations between time spent playing video games and increased risk for overweight (13,57). Television viewing and video-game use have also been combined in some studies by using a combined index of total “screen time” but it seems that they may have different effects. Some have suggested that the impact from television viewing may be more significant because it can reduce energy expenditure and increase energy intake. The amount of energy expended while watching television has been found to be as low as or lower than other sedentary activities (eg, doing schoolwork or crafts) (58).

In addition, television influences the type and amount of foods consumed by viewing children. A typical child watches approximately 40,000 commercials on television each year, a number that has doubled during the time that there has been a large increase in the rate of pediatric overweight (59). Fast foods, snack foods, and highly sugared foods are among the most heavily advertised items on children’s television programs (60). Commercials increase children’s desire and requests for the advertised food products (61,62) and contribute to unhealthful perceptions about food and nutrition (63). Indeed, television viewing among children has been related to a higher intake of fats, sweets, salty snacks, and fast food, and a lower intake of fruits and vegetables (37,64).

Although associations between television and overweight have been found in all segments of the population, some evidence suggests that the results may be confounded by socioeconomic status. Surveillance research indicates that frequent use of video games is more common in higher socioeconomic populations, whereas television viewing is generally higher among lower socioeconomic populations.

WHAT IS A PARENT TO DO? PARENTAL REINFORCEMENT AND RESTRICTION

Environmental conditions that promote energy intake and minimize energy expenditure have been major factors contributing to the increasing obesity epidemic (65). Because parents are responsible for the physical and social environments of young children, they are indisputably the first line of prevention for youth overweight. Research about parental reinforcement and restriction of food and physical activity has revealed that parents must walk a “fine line” when trying to promote healthful lifestyles in their children (66).

Parental Reinforcement/Restriction on Dietary Patterns

Research on parental influences of diet in relation to adiposity are largely based on studies by Birch and her colleagues using primarily white, middle-class, young girls, and thus findings must be extrapolated to other groups with caution. At present there are sufficient data to support the conclusion that in noncontrolling, noncoercive conditions in which children have access to a variety of healthful foods, young children have the ability to self-regulate the amount of food and energy consumed (67). Parents may negatively influence their children’s dietary intake and ability to self-regulate by either applying excessive external control or failing to offer healthful options. A high degree of parental control over a child’s dietary intake may disrupt natural systems of self-regulation, and limiting highly palatable foods that are in the home may actually promote the children’s desire for such foods, causing dysregulation of energy intake, overeating, and ultimately weight gain in children (68,69).

Television influences the type and amount of foods consumed by viewing children.

Some cross-sectional studies found positive associations between parental restriction of foods and child adiposity, most notably in the 2-year study of a cohort comprised of non-Hispanic, white, middle-class girls, age 5 to 7 years and their parents (68,70). Based on these limited observational studies, parental restriction of a child’s dietary intake of highly palatable foods may be associated with childhood adiposity; however, longitudinal analyses need to be conducted among larger, more diverse populations. Further, different styles of restriction must be evaluated (ie, not bringing foods of concern into the home vs buying them, but then restricting intake).

It has also been suggested that using food as a reward increases a child’s preference for that food, whereas pressuring or prompting a child to eat to obtain a reward (eg, making a child finish her vegetables before she can be excused to play) tends to decrease a child’s preference for the promoted food (71). Cross-sectional comparisons between parental pressure and encouragement and BMI at both baseline and after 2 years of follow-up found a sig-
1. Provide children with ample access to nutrient-dense foods and beverages, and high-fiber foods, both at meals and snack time.
2. Reduce children’s access to high-calorie, nutrient-poor beverages and foods, both at home and when eating away from home.
3. When nutrient-poor foods are available, avoid excessive restriction and use of food as a reward.
4. Encourage children to eat breakfast.
5. Work to find ways to increase fun and achievable physical activity in children.
6. Reduce children’s television and video game time.
7. Model healthful eating and physical activity practices for children.

**Figure.** What a parent can do to promote healthful eating and physical activity in children.

Studies have demonstrated that over the past 20 to 30 years, the percentage of meals and snacks eaten away from home increased from 16% to 27% (76), and the percentage of total energy consumed as food prepared away from home increased from 18% to 32% (77). The number of per capita fast-food restaurants in the United States has doubled, and the number of full-service restaurants has increased by 35% (78) to accommodate society’s demand for quick, accessible food (79).

The nature and pace of life in most families may make it more difficult for children to be physically active. The real (or perceived) safety issues in society also lead parents to prohibit their children from playing outside without direct adult supervision (80). This fact, combined with the ease and availability of many inactive pursuits, such as television and video games, have led to clear shifts in the way that children use their free time.

Parents can influence many diet- and activity-related behaviors that are associated with a child’s likelihood of developing obesity. One obesity prevention strategy for children is to enhance the effectiveness of parenting practices related to diet and physical activity/inactivity behaviors. Although parents cannot control all aspects of a child’s day, they can moderate type and availability of foods, feeding practices, the frequency of television/video game usage, and access to physical activity opportunities. Parental modeling of both eating habits and physical activity also can help shape children’s values, beliefs, and behaviors (81,82). Eating dinner with family has been associated with a more healthful diet: more fruits and vegetables, fewer fried foods, less soda, less fat, and more micronutrients (83). Being active as a family also creates norms and expectations about the importance of regular physical activity. Efforts to impose overly restrictive diets on children are detrimental and may, in fact, lead to future weight gain (84,85). Therefore, emphasis should be on the promotion of healthful eating and activity behaviors and not on weight status per se.

**RECOMMENDATIONS**

The nature of society has changed considerably in the past 20 years, and these changes have dramatically influenced the ways in which people live, eat, and play. Children are now more likely to have single parents or two working parents, either or both of whom may have multiple jobs (75). Time constraints make it harder for parents to provide healthful snacks and meals at home.

**ROLE OF HEALTH CARE PROFESSIONALS**

Health care professionals have regular interactions with parents and children and, therefore, are in an ideal position to discuss measures that may decrease the likelihood of the development of obesity. Recent recommendations from the Institute of Medicine report on preventing pediatric obesity include specific health care recommendations, which are incorporated into the list that follows.
(86). It is important to note that even without evidence-based proof of efficacy, recommendations that have the possibility of benefit, with no likelihood of risk, can be safely invoked until more data are forthcoming. Key recommendations for health care professionals are:

1. Clinicians should encourage the breast feeding of infants for several reasons, one of which is a possible protective effect in the prevention of childhood overweight. As solid foods are introduced, introduce them with no added salt or sugar. Because habits are formed during this period, encourage the use of healthful finger foods and beverages for toddlers rather than french fries and sweetened beverages.

2. Monitor BMI in children 2 years of age and older. Measure height and weight accurately, calculate BMI, and plot using the Centers for Disease Control and Prevention charts (87) to determine whether the child is already at risk for overweight (BMI ≥85th percentile for age) or obesity (BMI ≥95th percentile). Because simple visual observation can be misleading, BMI should be considered a vital sign just as important as pulse and blood pressure. If BMI is already elevated or if it is increasing across the percentile values for age with time, bring the issue to the parents’ attention gently, because they may be unprepared for the information, they may be in denial if they already realize the situation (“my family has big bones and all the children grow out of it”), or they may be in the stage of precontemplation and not yet prepared to initiate change (88).

3. Focus on healthful nutrition and physical activity habits for all families. Regardless of BMI value, healthful habits are beneficial for everyone and therefore should be addressed with all families.
   - Proactively counsel the family (anticipatory guidance) to limit screen time (television, computers, or video games) to 2 hours per day or less, eliminate television from the bedroom, and avoid television altogether before 2 years of age.
   - Encourage a decrease in all types of sedentary time, and increase physical activity without necessarily pushing for extremely vigorous activity in a sedentary child, as such efforts usually fail. When feasible, having children walk to school rather than taking a car can increase activity for many minutes per day.
   - Teaching the family to read food labels gives information that, with a common sense approach, can improve nutrition. Encourage the family to eat appropriate portion sizes and to select foods with lower amounts of calories and saturated fat.

4. Determine family history for risk factors (eg, early cardiac disorders or type 2 diabetes) and ethnic group (susceptibility to overweight and its comorbidities is greater in African Americans, Hispanic Americans, Native Americans, and some groups of Asian Americans), and follow screening recommendations (89). Informing the family of the risk for complications is important because many parents report that health care providers do not inform them of overweight risks.

5. Set behavior goals. Have parents and children make achievable and traceable goals and keep track of them daily. Encourage consumption of five or more servings per day of fruits and vegetables and 30 to 60 minutes of active play, for example, and have them place a star on a chart on the days when these goals are achieved. Encourage families to limit the number of times per week they patronize fast-food establishments. A general suggestion of “eat better and be more active” is far less likely to achieve success than specific quantifiable goals. Setting achievable behavior goals also will allow children to experience success and improve self-esteem, regardless of weight status (90).

6. Encourage parents to protect and promote self-esteem in children. Overweight children may be particularly at risk of low self-esteem and poor body image (91) because of the stigma associated with obesity (92-95).

7. Model healthy behaviors. The health care professional’s office and personnel should serve as role models. For example, if treats are called for, offer stickers or even vegetables and fruits rather than candy. Discussing the type of activities the health care providers and their own families engage in may encourage the patient to follow a similar pattern. Photographs, drawings, or equipment used as props might be displayed around the office as examples of after-hours and weekend activities.

8. Advocate for community change. Providers should use their standing in the community to support health-promoting civic actions. Encourage planning for side-walks to promote walking to schools and stores, for example. Support community “walking school bus” programs in which adults supervise and accompany a daily walk to and from school to minimize danger and encourage physical activity. Champion legislative efforts to regulate advertising and food promotions aimed at children. Encourage restaurants to provide smaller portion sizes and more healthful options in kids’ meals and menus. Suggesting that the school district maintain healthful dietary items, ban soda and candy sales, and teach appropriate nutrition and activity habits can go a long way to instituting such changes within the school environment. Advocating for parenting and healthful cooking classes in high schools and adult education programs can impact young and future parents.

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**Health care professionals should inform, encourage, and support parental efforts to promote healthful habits among all children and thereby prevent pediatric overweight.**

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**FUTURE DIRECTIONS**

Families represent a crucial environmental influence in the development and maintenance of healthful eating and physical activity habits among children. Health care
professionals should inform, encourage, and support parental efforts to promote healthful habits among all children and thereby prevent pediatric overweight. To this end, providers who work with families need to be aware of the key dietary, activity, and parenting behaviors that are most likely to be successful in preventing weight gain in children. However, providers must also recognize that without the broader support of the community and change in environmental influences outside of the family, it is inevitable that even some of the most well-meaning and best informed parents will fail in their efforts to have their children adopt healthful lifestyles. Barriers to positive action lie in many domains, such as work schedules, children’s behavior issues, community safety and security, and accessibility to health-promoting foods and activities (80). Health care professionals are ideally positioned to both counsel parents and to influence the broader community changes that are necessary to support parental actions.

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**ADA Evidence Analysis Library**

*Esther F. Myers, PhD, RD*

The American Dietetic Association’s (ADA’s) Evidence Analysis Library is an online reference that provides a systematic review and analysis of published research pertinent to dietetics that dietetics professionals can utilize to support patient and client recommendations. One important category included in the library is Childhood Overweight. This information is organized into four major subcategories: child nutrition, physical activity and inactivity, social influences on childhood overweight, and interventions for addressing childhood overweight. In each category, questions are presented and answered using the evidence analysis methodology described in detail in the Evidence Analysis Library. The research to support each question is critically appraised, summarized, and graded in terms of the strength or weakness of the evidence presented. ADA uses a grading system to define the strength of the research. Grades I, II, and III correspond to strong, fair, and weak; Grade IV designates expert opinion only; and Grade V stands for “not assignable,” meaning that there is insufficient evidence available that directly supports or refutes the conclusion.

The child nutrition subcategory includes questions on types of foods and eating behaviors. It also displays the large body of research showing a relationship between caloric intake and fat intake with prevalence of childhood overweight. The relationship between prevalence of overweight and intake of sweetened beverages, fruit juice, dairy and calcium, and fruits and vegetables is included under types of food. The eating behaviors section addresses breakfast skipping, eating frequency, eating out, food insecurity, portion size, and snacking behaviors.

Another subcategory addresses the relationship between physical activity and inactivity with respect to the prevalence of childhood overweight. Specific questions relate to television viewing, video games, physical activity, and sports activity.

The social influences subcategory addresses family influences such as family functioning, parental attitudes toward their own intake, parental concern about or criticism of child’s weight status, encouragement or pressure to eat, parental control over child’s dietary intake, parental restriction of highly palatable foods, and using food as a reward. The interventions addressing childhood overweight includes a summary of community-based interventions, individual- and family-based interventions, and school-based interventions.

In addition to Childhood Overweight, the Evidence Analysis Library currently provides a synthesis of the research on dietetic practice questions related to hyperlipidemia and critical illness. More than a dozen nutrition-related, evidence-based projects are also ongoing, focusing on topics such as adult weight management, bariatric surgery, congestive heart failure, gluten intolerance, human immunodeficiency virus, hypertension, oncology, pediatric weight management, and spinal cord injury. Information will be added to the Evidence Analysis Library as projects are completed. Future topics include chronic obstructive pulmonary disease, chronic kidney disease, and unintended weight loss.

The Evidence Analysis Library is available to all ADA members and can be accessed from the ADA Members Only page by clicking on the research tab on the left or by visiting www.eatright.org/Member/index_10708.cfm. Nonmembers can access a preview of the Evidence Analysis Library from the ADA public research page at www.eatright.org/Public/index_9916.cfm.

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